FINAL REPORT

ESSEX COUNTY (Tappahannock)

Riverside Tappahannock Hospital
Small Rural Hospital Improvement Grant Program (SHIP)

Virginia Department of Health
Office of Minority Health and Public Health Policy

Medicare Rural Hospital Flexibility Program (FLEX)
Agreement through the Virginia Rural Health Resource Center

Submitted by:

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CONGREGATIONAL HEALTH RESOURCE, LLC
Wholeness through health & faith-based solutions

December 31, 2009

EXECUTIVE SUMMARY

Over one half of Virginia's population attends church.[1] By leveraging the 7,000+ congregations (*excluding African American Congregations) of the Commonwealth as a force multiplier, the reach of public health can be much more extensive and effective. As one global mission group notes, the church is the "only community-based organization that is found in virtually every community in this country. It is able to reach people of all ages, races, and economic backgrounds and it can strongly influence people's values and personal life choices. Because the church is generally more integrated into the life of individuals and communities than our modern medical establishment, it can better enable people to assume responsibility for their own health."[2]

Yet churches are clearly underutilized as community health partners and lack health expertise and resources. By uniting the best practices of public health with faith-based principles and organizations, we can begin to close the gaps as health inequities are identified and their root causes are addressed at the core of communities. Congregational health (see Appendix A) brings together the best practices of public health and congregational-based principles by emphasizing wellness, wholeness, prevention, and education. When considering public health, it cannot be ignored.

Through collaborations and partnerships with other congregations and local, state, and national organizations, the church can provide quality health information and core health-related services to its members. However, a more formal process needs to be developed and implemented in local congregations. The Virginia Department of Health (VDH) has an opportunity to maximize the capacity of public health and can take steps in closing the gap by supporting future efforts.

Toward this goal, the Congregational Health ReSource, LLC (CHR) was commissioned by the Virginia Department of Health, Office of Minority Health (VDH OMHPHP) to perform congregational health assessments using federal Medicare Rural Hospital Flexibility Program (FLEX) funds. The assessments were designed to fulfill the shared mission of each partner: to address the health needs of congregations by using public health ideas and efforts.

In this pilot program, CHR was tasked with developing five congregational health assessments (clergy, civic, medical, government, and education) (see Appendix B), surveying Essex County, Virginia, and providing recommendations to VDH OMHPHP and the community based on the findings. This pilot study is among the first faith-based efforts by the Commonwealth at a community-wide level focusing on a rural community.

Survey Findings

Essex County has a total population of nearly 11,000 people. The Caucasian (59%) and African American (38%) populations make up the majority of races in this county.[3] The average income is nearly $47,000.[4] Almost 74% of these individuals graduated from high school or higher and with a bachelor's degree or higher ~17%.[5] Of those congregations completing surveys for this pilot, most are Evangelical, have been established for longer periods of time, and have an average size congregation of less than 200 members. Over 60% of the membership is comprised of senior, female adults. The statistics for the congregations reveal that the churches are very segregated by race.

While only 3 (n=16) congregations mentioned having an active health ministry, all of the churches already support the health of their members in other ways. All respondents said that they believed that there is a connection between physical, emotional, and spiritual health and all but one, who was "not sure," felt it was the role of religious institutions to help their congregations be physically healthy.

Thirteen of the pastors indicated that they would be willing to offer health education, services, and materials to their congregations, while three stated that they were "unsure." The clergy also indicated that the main reason they did not have a health ministry is because of a lack of finances followed by uncertainty about how to start one. This is an indicator that there is a great interest in developing a "health ministry" if the finances were available and if guidance was offered.

The pastors stated that they faced a number of barriers affecting the health of their members in their community, including cultural, socioeconomic, social environment, and a variety of others (e.g., disabilities, domestic violence, mental illness, lack of healthy foods/affordable and healthy food choices, and lack of access to physical activities). And, among the top concerns of these pastors are aging, heart disease, and cancer. These concerns are consistent with the major causes of death in Virginia.[6]

A total of 38 satisfactory responses were received from all sectors of the community (civic, clergy, education, government, and medical). Each sector expressed an interest in assisting local congregations and faith-based organizations. Many were interested also in developing partnerships with the same as long as the need is indicated and identified.

As a result of this pilot survey, CHR recommends developing 1) a model health ministry program at a state-wide level, 2) a health ministry toolkit/manual, 3) a church member survey, and 4) a pilot model rural health ministry program for congregations, as well as continuing future research. Engaging the faith community in these recommendations is essential to program success.

CHR also recommends the following to produce an increased response to future surveys: 1) convene a town hall meeting once key leaders are identified, 2) develop focus groups based on the community sector, 3) offer incentives to complete the survey, 4) identify successful and active health ministries in local congregations to mentor or partner with other churches, 5) develop a model health ministry program at a statewide level, 6) develop a health ministry toolkit/manual, 7) develop an individual church member survey, 8) develop a model rural health ministry program, and 9) continue future research.

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[1]Religious Congregations and Membership in the United States, 2000. Collected by the Association of Statisticians of American Religious Bodies (ASARB) and distributed by the Association of Religion Data Archives (www.theARDA.com) http://www.thearda.com/mapsReports/reports/state/51_2000.asp (*Congregational "adherents" include all full members, their children, and others who regularly attend services. The historically African American denominations are not included in the 2000 congregation and membership totals. Many are also missing in 1990, and most historically African American denominations are missing in the 1980 reports.)

[2]Health and Welfare Ministries, General Board of Global Ministries, The United Methodist Church, New York, New York

[3]US Census Bureau, 2008 Population Estimates for Virginia. http://factfinder.census.gov/servlet/QTTable?_bm=y&-context=qt&-qr_name=PEP_2008_EST_DP1&-ds_name=PEP_2008_EST&-CONTEXT=qt&-tree_id=808&-redoLog=false&-_caller=geoselect&-geo_id=04000US51&-geo_id=05000US51057&-search_results=01000US&-format=&-_lang=en

[4, 5] http://www.city-data.com/county/Essex_County-VA.html

[6]Virginia Department of Health, Office of Minority Health & Public Health Policy, *Virginia Health Equity Report 2008, Executive Summary*